HealthChoice Substance Abuse Treatment Self-Referral Protocols – in ASAM Order
Substance Abuse Improvement Initiative (SAII)
January 1, 2010

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
Comprehensive Substance Abuse Assessment (CSAA)				
H0001	NA	NA	(1) An Managed Care Organization (MCO) or the Behavioral Health Organization (BHO) which administers the substance abuse services for certain MCOs will pay for a Comprehensive Substance Abuse Assessment once per enrollee per provider per 12-month period, unless there is more than a 30-day break in treatment. If a patient returns to treatment after 30 days, the MCO/BHO will pay for another CSAA.	The same rules for HealthChoice apply for PAC.

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ASAM Level: I-Outpatient Services (Ambulatory detox) – In this context, ambulatory detox refers to services provided in the community or in outpatient departments of hospitals or ICF-As. It is only covered under HealthChoice.				
H0014 for community-based providers using CMS 1500 0944 and 0945 revenue codes for facility-based providers using UB-04	Provider must notify MCO/BHO and provide treatment plan (by fax or email) within one (1) business day of admission to ambulatory detox.	MCO or BHO liaison will respond to provider within one (1) business day of receipt with final disposition concerning ASAM criteria, including confirmation number if approved.	1) If MCO/BHO **does not** respond to provider's notification, MCO/BHO will pay up to five (5) days. 2) If MCO/BHO responds by approving authorization, a LOS of five (5) days will automatically be approved. Additional days must be preauthorized as meeting medical necessity criteria. 3) If MCO/BHO determines client does **not** meet ASAM LOC, MCO/BHO will pay for care up to the point where they formally communicate their disapproval.	Ambulatory detox is not covered by the PAC program.

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ASAM Level: I – Outpatient Services (Individual, family, and group therapy) – Self-referred individual, family or group therapy services must be provided in the community (not in hospital rate regulated settings).[1] [2]				
H0004 for individual or family therapy H0005 for group therapy	Provider must notify (by fax or email) MCO/BHO and provide initial treatment plan within three (3) business days of admission to Level I therapy services	MCO or BHO liaison must respond to provider within two (2) business days of receipt with confirmation of receipt of notification.	MCO/BHO will pay for 30 self-referred sessions (any combination of individual, group, and family therapy) within 12-month period per client. Any other individual or group therapy services within the 12-month period must be preauthorized. Medicaid MCOs/BHOs will pay for additional counseling services as long as deemed medically necessary. In order for a provider to bill for family counseling, the enrollee must be present for an appropriate length of time, but does not need to be present for the entire counseling session. In some circumstances the counselor might spend part of the session with the family out of the presence of the enrollee. Family therapy is billed under the individual enrollee's Medicaid number.	PAC only covers Level 1, individual, family, and group therapy in community-based settings. All other approval rules for HealthChoice apply for PAC.

[1] Hospital rate regulated clinics must seek preauthorization to provide such services under HealthChoice. In preauthorizing, MCO may refer to in-network community providers if those providers are easily available geographically and with no waiting lists.
[2] Hospital-based services are not covered under PAC.

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ASAM Level: II.1 – Intensive Outpatient (IOP – intensive outpatient) - Self-referred intensive outpatient services only apply to care delivered in community-based settings. Hospital rate regulated clinics must seek preauthorization to provide such services[3].				
H0015 for community-based providers using CMS 1500 0906 revenue codes for facility-based providers using UB-04	Provider must notify and provide treatment plan to MCO (by fax or email) within three (3) business days of admission to IOP. If they do not notify, they will not be paid for services rendered.	MCO or BHO liaison will respond to provider (by fax or email) within two (2) business days with final disposition concerning ASAM criteria, including confirmation number if approved.	If the treatment plan is approved, MCO/BHO will pay for 30 calendar days of IOP. At the end of week three (3), for care coordination purposes, the provider must notify the MCO of discharge plan or need for remaining treatment. Continuing treatment beyond the 30 days must be preauthorized as being medically necessary. If determined that client **does not** meet ASAM LOC, MCO/BHO will pay for all services delivered up until the point that they formally notify the provider of the denial. If the client does not qualify for IOP, the MCO/BHO will work with the provider to determine the appropriate level of care.	The same approval rules for HealthChoice apply for PAC. PAC providers must bill using the CMS 1500 form and the H0015 for PAC recipients.

[3] Hospital regulated clinics must seek preauthorization to provide services under HealthChoice. In preauthorizing, MCO may refer to in-network community providers if those providers are easily available geographically and with no waiting lists. Hospital regulated clinics are not covered under the PAC program.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: II.5 – Partial Hospitalization (Partial hospitalization (adults and children)) - HealthChoice reimburses this service only when it occurs in a hospital or other facility setting. It is not covered under PAC.				
0912 and 0913 revenue codes for facility-based providers using UB-04	By morning of second day of admission to this service setting, provider will review client's Treatment Plan with MCO/BHO by telephone. Provider must submit progress report **and** assessment for justification of continued stay beyond day five (5). Provider obtains patient consent and submits progress report or discharge summary to PCP for their records and coordination of care within 10 days.	MCO or BHO liaison will respond to providers within two (2) hours of review. Confirmation number will be provided. MCO/BHO must have 24/7 availability for case discussion with provider.	1) Two (2) day minimum guaranteed. If ASAM is met, MCO/BHO will authorize an additional three (3) days. Any additional days must be preauthorized by the MCO based on medical necessity. 2) If the MCO/BHO is **not available or does not respond** to provider within two (2) hours, they will pay the extra three (3) days. Any additional days must be preauthorized by the MCO/BHO based on medical necessity. Providers shall provide the least restrictive level of care. If the client does not qualify for partial hospitalization, the MCO/BHO will work with the provider to determine the appropriate level of care.	Partial hospitalization is not covered by the PAC program.

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ASAM Level: III – Residential and Inpatient (ICF-A, under 21) - HealthChoice only covers ICF-A for children and adolescents under age 21 as long as medically necessary and the enrollee is eligible for the service. HealthChoice does not pay for ICF-A services if they are not medically necessary, even if a Court has ordered them. HealthChoice doesn't cover other residential services. In addition, ICF-A and other residential services are not covered under PAC.				
Providers should speak to MCOs/BHOs about appropriate codes to use within their billing systems	Within two (2) hours, provider calls MCO or BHO for authorization.	MCO/BHO liaison will respond to provider within two (2) hours with a final disposition concerning ASAM criteria, including confirmation number if approved. MCO/BHO must have 24/7 availability.	1) If MCO **does not** respond to urgent call, up to three (3) days will be paid. Additional days must be preauthorized. 2) If ASAM is met and MCO/BHO has authorized, a LOS of three (3) days will be approved. Additional days must be preauthorized. 3) If client does not meet criteria, the MCO/BHO will work with provider to determine appropriate level of care.	ICF-A and other residential programs are not covered by the PAC program.

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ASAM Level: Opioid Maintenance Treatment (Methadone) - In regards to the self-referral option under HealthChoice, methadone maintenance refers to services provided in the community or in outpatient departments of hospitals. It will not however be covered under PAC.				
H0020	Within five (5) calendar days of admission to methadone program, provider notifies MCO/BHO (by fax or email) and submits initial treatment plan. The provider will submit an updated treatment plan to the MCO/BHO by the 12th week of service to promote the coordination of care. Next approvals will be at six-month intervals.	MCO or BHO will respond to provider within two (2) business days (by fax or email) with final disposition, including confirmation/ authorization number if approved. The provider will inform the PCP that patient is in treatment after obtaining the patient's consent.	If approved, MCO/BHO will pay for 26 weeks under the self-referral option. Continued eligibility for coverage will be determined by medical necessity. Additional approvals beyond the first 26 weeks will be at six-month intervals. Unit of service is one week. Any care provided prior to a denial based on medical necessity will be paid by the MCO/BHO.	PAC covers methadone treatment only in a community-based setting (not hospital). All other HealthChoice approval rules apply. PAC providers must bill using the CMS 1500 and the H0020 code.

Billing Codes: Sub Abuse TX & Procedure Codes	Provider Communication Responsibility	MCO/BHO Communication Responsibility	HealthChoice Approval Criteria	PAC Approval Criteria
ASAM Level: IV.D -Medically Managed Patient (Inpatient detox in an inpatient hospital setting or ICF-A facility) - This service is provided in a hospital or ICF-A setting and is only covered under HealthChoice.				
0126 and 0136 revenue codes for facility-based providers	Within two (2) hours, provider calls MCO/BHO for authorization.	MCO or BHO will respond to provider within two (2) hours with a final disposition, including confirmation number if approved. MCO/BHO must have 24/7 availability.	If ASAM is met and MCO/BHO authorizes, a LOS of three (3) days will be approved. Additional days must be preauthorized as medically necessary. If client does not meet criteria, the MCO/BHO will work with provider to determine appropriate level of care. If MCO/BHO does not respond to the provider's authorization call, up to three (3) days will be paid. Additional days must be preauthorized as medically necessary.	Inpatient detox is not covered by PAC.

Footnotes

1. MCOs/BHOs must have 24/7 availability for Partial Hospitalization, ICF-A, and Inpatient Acute. These services are only covered under HealthChoice.
2. MCOs/BHOs will honor substance abuse authorizations for all services made by an enrollee's previous MCO provided the ASAM level of care continues to be met and there is no break in service. The provider must submit written verification of this authorization to the new MCO within 72 hours of receiving it from the previous MCO.
3. MCOs pay the full FQHC per visit rate for services rendered for HealthChoice patients. MCOs do not have to pay the full FQHC rates for PAC patients.
4. An MCO/BHO may not require a peer-to-peer review for a pre-certification in cases where the patient is new and has not been seen by the provider's physician.
5. An MCO/BHO may not require written approval from a commercial insurer before deciding on a preauthorization in cases where the patient has dual insurance.
6. Proof of notification is the faxed confirmation sheet and/or a documented phone conversation (date, time and person spoken to).
7. "One session" means a face-to-face meeting with a provider.

☞**Note: HealthChoice regulations require the use of a placement appraisal to determine the appropriate level and intensity of care for the enrollee-based on the current edition of the American Society of Addiction Medicine Patient Placement Criteria, or its equivalent as approved by the Alcohol and Drug Abuse Administration for most services covered under this protocol.**

Department of Health and Mental Hygiene website: http://www.dhmh.state.md.us/
DHMH Provider Hotline: 1-800-766-8692
Or call the Complaint Resolution Unit's supervisor, Ellen Mulcahy-Lehnert, or Division Chief, Ann Price, at 1-888-767-0013 or 1-410-767-6859 from 8:30 AM to 4:30 PM Monday - Friday